ICD-9-CM Coding Guidance for LTC Facilities

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_048122.hcsp?dDocName=bok1_048122

Diagnostic coding plays several important roles in every healthcare setting, including long-term care (LTC) nursing facilities. LTC facilities assign ICD-9-CM codes to capture a resident's clinical conditions.

ICD-9-CM facilitates the collection and organization of healthcare statistics on the incidence of diseases. Diagnostic coding is used to:

- Collect diagnostic and statistical data about persons treated by healthcare providers
- Support clinical decision making
- Support reimbursement for services provided
- Comply with federal standards for reporting diagnostic data
- Provide data to support clinical research and quality improvement activities

HIPAA requires that healthcare providers, including LTC facilities, follow the guidance and direction in the ICD-9-CM code system and the "ICD-9-CM Official Guidelines for Coding and Reporting." LTC facility staff should be knowledgeable of ICD coding guidance to ensure appropriate billing and reimbursement.

Knowledge of ICD coding guidance also will help ensure a smooth ICD-10-CM implementation effective October 1, 2013. (Appendix A offers guidance on how LTC facilities can prepare for the ICD-10-CM transition.)

LTC facilities must educate staff who work with or assign ICD-9-CM codes on the rules and regulations related to proper code assignment, especially for principal diagnosis. This practice brief provides guidance on determining the correct principal diagnosis in LTC facilities.

ICD-9-CM Coding and Reporting Guidelines

The "ICD-9-CM Official Guidelines for Coding and Reporting" is the companion document to the official version of ICD-9-CM as published by the US Government Printing Office. The guidelines are approved by the four organizations that make up the Cooperating Parties for ICD-9-CM: the American Hospital Association (AHA), AHIMA, the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics.

The guidelines are included in the official version of ICD-9-CM and also appear in *Coding Clinic for ICD-9-CM*, which is published quarterly by AHA.[1] *Coding Clinic* provides guidance on interpreting and applying the ICD-9-CM guidelines.

HIPAA requires adherence to these guidelines when assigning ICD-9-CM diagnosis

codes.[2]

The Cooperating Parties developed the LTC coding guidance in conjunction with the *Coding Clinic's* editorial advisory board. The LTC coding guidance was published in the 1999 fourth quarter issue of *Coding Clinic*.

The guidance has assisted LTC facilities on how the "ICD-9-CM Official Guidelines for Coding and Reporting" should be interpreted and applied in nursing homes, as it was recognized that LTC services are dynamic, depend on many factors, and cover a longer time frame than acute care stays. The guidance was established in order to standardize data collection and assist coding professionals in LTC facilities.[3]

Assigning ICD-9-CM codes in LTC is unique, as residents often remain in facilities after their initial episode of illness is resolved. For example, a resident may be admitted to receive rehabilitation services for a healing hip fracture but be unable to return home and continue to reside in the facility for other chronic conditions such as Parkinson's disease, chronic obstructive pulmonary disease (COPD), or chronic kidney disease.

ICD-9-CM codes are assigned on admission and concurrently as diagnoses arise throughout a stay, often when the Minimum Data Set (MDS) is updated. Codes can be assigned at different intervals, such as a resident's discharge, transfer, or expiration. All diagnoses (e.g., chronic conditions) that affect the resident's care are coded per coding guidelines.

Diagnostic listing and sequencing will vary depending on the circumstances of the resident's admission or continued stay in the facility.

Principal Diagnosis Definition and Guidance

Similar to other providers, LTC facilities have varying rules and regulations that require coded data. At times, there may be a conflict in the requirements and terminology. For example, the term *primary diagnosis* is often used to indicate the reason for skilled Medicare services, which may not be the same reason for the resident's continued stay. Therefore the term*primary diagnosis* may conjure different definitions, depending on the individual.

For consistency in this practice brief, the term *principal diagnosis* indicates the principal, primary, and first-listed diagnosis (see "Terms for Principal Diagnosis" at left for more information). Section II of the "ICD-9-CM Official Guidelines for Coding and Reporting" defines principal diagnosis and offers guidance on its selection. The Uniform Hospital Discharge Data Set defines principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."[4]

This definition has been expanded to include all nonoutpatient settings including LTC facilities. *Coding Clinic* further states that for residents who continue to stay in LTC facilities, the condition requiring the resident to stay should be sequenced first.[5]

Current LTC residents who transfer to the hospital to receive treatment for acute conditions (e.g., pneumonia) and return to the facility for further care of their chronic

condition (e.g., COPD) may continue to receive care for the acute condition if unresolved. The principal diagnosis (first-listed) is the reason for the continued stay (e.g., COPD) in the nursing facility.

A newly diagnosed condition will be listed after the principal diagnosis to reflect new conditions that affect the resident. (The principal diagnosis may or may not be the reason for Medicare skilled services.) For more examples of coding continued stays, see the sidebar below.

Coding for Continued Stay

Current LTC residents who transfer to the hospital to receive treatment for acute conditions (e.g., pneumonia) and return to the facility for further care of their chronic condition (e.g., COPD) may continue to receive care for the acute condition if unresolved. The principal diagnosis (first-listed) is the reason for the continued stay (e.g., COPD) in the nursing facility.

A newly diagnosed condition will be listed after the principal diagnosis to reflect new conditions that affect the resident. (The principal diagnosis may or may not be the reason for Medicare skilled services.)

Example 1: Initial Admission Followed by Continued Stay

A resident was initially admitted to a LTC facility to receive physical and occupational therapy services due to aftercare for a healing hip fracture. The resident remains in the facility because of his Parkinson's disease.

Upon initial admission, the following codes would be reported:

- V57.89, Multiple therapies
- V54.13, Aftercare for healing traumatic fracture of hip (repaired with ORIF)
- 332.0, Parkinson's disease

Codes V57.89 and V54.13 are resolved and documented (usually at discontinuation of Medicare Part A stay).

For the continued stay, code 332.0, Parkinson's disease, becomes the principal/primary diagnosis (reason for continued stay).

A year later the resident is transferred to the hospital for treatment of pneumonia and returns to the nursing facility after a three-day hospital stay with an order for physical/occupational therapies and antibiotics.

Upon returning to the facility, the following codes would be reported:

- 332.0, Parkinson's disease (reason for return to the facility) as principal/primary diagnosis
- 486, Pneumonia with therapies documented for all to know that

therapies are included.

Code category V57 would *not* be assigned or listed on the record or the claim form because code category V57 can only be a first-listed diagnosis. (See appendix C for additional guidance from the official guidelines.)

The resolved pneumonia would be documented by the physician. The Medicare Part A stay would be discontinued when skilled nursing and therapy services are no longer medically necessary; however, the resident continues to stay in the LTC facility.

Code 332.0, Parkinson's disease, remains the principal diagnosis (reason for continued stay).

Example 2: Continued Stay Only

A resident residing in a nursing facility since experiencing a cerebrovascular accident with residuals several years ago is transferred and treated in the hospital for pneumonia. The resident continues to receive oral antibiotics for the pneumonia.

Upon return to the facility, the following codes would be reported:

- Appropriate code(s) from category 438, Late effect of cerebrovascular disease, as the first-listed diagnosis to identify the neurologic deficits, which resulted from the acute CVA.
- 486, Pneumonia, as a secondary diagnosis, for as long as the patient receives treatment for the condition.[1]

Note

1. American Hospital Association. *Coding Clinic for ICD-9-CM* 16, no. 4 (Fourth Quarter 1999).

Principal Diagnosis in Other Regulations

The Medicare Program Integrity Manual refers to the term *primary diagnosis* as the diagnosis that is the reason for therapy services. This diagnosis is also known as the medical diagnosis.

The Therapy Evaluation and Plan of Care document for new Medicare Part A stays requires the medical reason support the therapy services as documented by the physician or qualified practitioner. The diagnostic code representing the medical reason may be identified as "primary diagnosis" or "medical diagnosis" on the therapy plan. Again, this medical diagnosis may not be the same diagnosis as the reason for the continued stay (principal, primary, or first-listed diagnosis) in the facility.

For example, a patient with Parkinson's disease returns after a hospitalization for

pneumonia to start a new Medicare Part A stay. Pneumonia is identified as the medical diagnosis on the therapy evaluation and plan of care to support the skilled therapy services along with the appropriate therapy treatment diagnoses. However, Parkinson's disease is the reason for the continued facility stay and continues to be sequenced first on the record and the UB-04. The reason for the new focus of care and Medicare Part A stay (e.g., pneumonia) is sequenced second.

The Resident Assessment Instrument User's Manual provides instructions for reporting diagnoses to develop individualized care plans for residents. Diagnoses are part of the MDS. Section I of the MDS 3.0, titled "Active Diagnoses," is intended to "code disease related to the resident's functional, cognitive, mood or behavior status, medical treatments, nursing monitoring or risk of death."[6]

The term *code* in the MDS 3.0 does not hold the same meaning as ICD-9-CM code. "Coding" the MDS is the process of assigning values (i.e., numbers, check marks, or dashes) to the MDS items. However, ICD-9-CM diagnosis codes may be listed on the MDS.

The MDS contains common active diagnoses that are checked on the form if present; however, a resident may have other conditions. The other conditions are listed in the additional active diagnosis section and require an ICD-9-CM code in addition to the text.

The Medicare Claim Processing Manual instructs LTC staff to follow HIPAA's guidance for adhering to instructions in ICD-9-CM and the official guidelines. Appendix B offers guidance on reporting and sequencing diagnoses in the health record and UB-04 claim form.

Terms for Principal Diagnosis

LTC facilities have varying rules and regulations that require coded data. At times, there may be a conflict in the requirements and terminology. For example, the term *primary diagnosis* is often used to indicate the reason for skilled Medicare services, which may not be the same reason for the resident's continued stay. Therefore the term *primary diagnosis* may conjure different definitions, depending on the individual.

Below are the definitions of the different terms for principal diagnosis:

- **First-listed diagnosis:** the diagnosis that is sequenced first. Terms *principal* and *primary* are often used interchangeably to define the diagnosis that is sequenced first.
- **Principal diagnosis:** condition established after study to be chiefly responsible for the patient's admission to the hospital. It is always the first-listed diagnosis on the health record and the UB-04 claim form. This direction applies to nursing homes as stated in the guidelines.
- **Primary diagnosis:** this term is often used to indicate the reason for the continued stay in the LTC facility. It is also used interchangeably

with principal diagnosis.

Note: The Medicare Program Integrity Manual refers to the term *primary diagnosis* as the diagnosis that is the reason for therapy services. This diagnosis is currently referred to as the medical diagnosis for the therapy evaluation and plan of care and may or may not be the principal, primary, or first-listed diagnosis.

Use of V Codes in LTC Facilities

Assigning V codes has long been an area of confusion and controversy. Many facilities are told not to assign V codes as the principal diagnosis or even at all. The ICD-9-CM code set and the official guidelines provide specific instruction for appropriate use of V codes.

In long-term care, one of the most common reasons for initial admission is rehabilitation services (e.g., physical, occupational, and speech-language therapy). Section I.B.15 states:

When the purpose for the admission/encounter is rehabilitation, sequence the appropriate V code from category V57, Care involving use of rehabilitation procedures, as the principal/first-listed diagnosis. The code for the condition for which the service is being performed should be reported as an additional diagnosis. Only one code from category V57 is required. Code V57.89, Other specified rehabilitation procedures (multiple therapies), should be assigned if more than one type of rehabilitation is performed during a single admission.[7]

Category V57 codes can be assigned only as the principal diagnosis as specified in section I.C.18.e., "V Codes That May Only Be Principal/First-Listed Diagnosis."[8]

V codes also are frequently assigned for aftercare following orthopedic or surgical procedures to support therapy services. These V codes cover situations "when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare V code would not be used if treatment is directed at a current, acute disease or injury."[9] Examples of aftercare codes include:

- V54.13, Aftercare for healing traumatic fracture of hip
- V58.75, Aftercare following cholecystectomy (surgery of the digestive system) for a patient who has gallbladder removal at the hospital
- V58.73, Aftercare following resection of abdominal aneurysm (surgery of the circulatory system), with repair performed in the acute hospital

Codes for the acute medical condition treated in the hospital are assigned and reported by the hospital (e.g., acute fracture, cholecystitis, abdominal aneurysm) but not coded or reported in the LTC facility. LTC facilities report V codes to identify the provision of aftercare.

Reporting an acute code for a resolved condition on the health record or claim is

inaccurate because it directly contradicts official coding guidelines. It is also potentially fraudulent and out of HIPAA compliance.

Diagnosis List and UB-04 Claim Form

Residents in LTC facilities often have numerous chronic conditions. The diagnosis list is a comprehensive listing of these numerous conditions, which are often listed in order of focus and complexity of care for the resident.

The number of diagnoses listed can be extensive and usually exceeds current reporting capacity. CMS has proposed expanding the capacity for fiscal year 2011. Additional diagnostic fields will be available with the implementation of the UB-04 (version 5010) effective January 1, 2012.

Prior to claims submission, facilities must validate that the data coded in ICD-9-CM are consistent with health record documentation, MDS, and the UB-04. This is commonly referred to as a triple-check process. Consistent diagnostic coded data on the health record, MDS, and UB-04 claim form will support the claim. Since reimbursement is determined by the Resource Utilization Group category based on the MDS assessment data items, the facility will receive the appropriate reimbursement.

Prior to claims submission, it is also important that the facility select the appropriate codes for the UB-04. Facilities must determine and report diagnoses required to support services being billed. Principal diagnosis is located in field 67A on the claim form.

There is no strict hierarchy inherent in the ICD-9-CM guidelines regarding the sequencing of secondary diagnosis codes.[10] When diagnoses are sequenced together following instructions such as "use additional code" or "code underlying condition first," the official guidance does not require that the secondary diagnosis code be reported immediately following the code for the related condition. This allows flexibility in selecting the additional diagnoses.

Facilities are not required to report additional diagnoses on the UB-04 in the order in which they are listed on the diagnosis list. Appendix C offers regulatory guidance on reporting diagnoses related to reimbursement.

Medicare Part B Therapy Services

Medicare Part B therapy services also require medical necessity for treatment, identified by a medical diagnosis. The medical diagnosis that identifies the reason for the Part B therapy services should be listed after the reason for the continued stay. Other ICD-9-CM codes for chronic conditions that affect the resident's progress may also be reported to support therapy services.

Section IV in the official guidelines clearly states that the coding guidelines for outpatient diagnoses have been approved for use by hospitals and providers to code and report hospital-based outpatient services and provider-based office visits.[11] They are not used for Part B therapy services for residents in LTC facilities because nursing homes are identified as a nonoutpatient setting in section II.[12]

For a current resident receiving Part B therapy services, the principal diagnosis reported on the UB-04 is the reason for the continued stay in the LTC facility. A category V57 code would *not* be assigned because the principal diagnosis for billing these services can only be assigned as the principal diagnosis.

Data fields on the UB-04 (such as bill type, specific line items for therapy services, and the appropriate medical and treatment diagnoses) along with accurate and complete documentation in the health record will support appropriate reimbursement for Medicare Part B services.

Medical Reviews

With the increase in third-party audits from entities such as the Office of Inspector General (OIG), Recovery Audit Contractors, and Medicaid Integrity Contractors, it is imperative that LTC facilities understand the guidance in ICD-9-CM and the guidelines for coding and reporting as required by HIPAA.

In the "Compliance Program Guidance for Nursing Facilities," OIG recommends that a nursing facility take all reasonable steps through its policies and procedures to ensure compliance with the federal healthcare programs when submitting information that affects reimbursement decisions. It states:

A key component of ensuring accurate information is the proper and ongoing training and evaluation of the staff responsible for coding diagnoses and regular internal audits of coding policies and procedures. With the arrival of consolidated billing and the next edition of the coding manuals, it will be even more critical that knowledgeable individuals are performing these coding tasks. The risk areas associated with billing and cost reporting have been among the most frequent subjects of investigations and audits by the OIG.[13]

In order to ensure compliance, LTC facilities must have sound coding policies and procedures, including the current edition of the "ICD-9-CM Official Coding Guidelines for Coding and Reporting" and a current subscription to *Coding Clinic*. Lack of these resources may result in improper coding and reporting, thus resulting in inaccurate data.

Credentialed HIM professionals possess valuable knowledge and expertise that will benefit LTC facilities, especially as the industry prepares for ICD-10-CM. Ensuring accurate coded data will continue to play an important role in the LTC industry.

Notes

1. Centers for Disease Control and Prevention, National Center for Health Statistics (CDC). "ICD-9-CM Official Guidelines for Coding and Reporting." Available online at www.cdc.gov/nchs/data/icd9/icdguide10.pdf.
2. Ibid.
3. American Hospital Association (AHA). *Coding Clinic for ICD-9-CM* 16, no. 4 (Fourth Quarter 1999): 3.
4. CDC. "ICD-9-CM Official Guidelines for Coding and Reporting."
5. AHA. *Coding Clinic for ICD-9-CM* 16, no. 4 (Fourth Quarter 1999): 3.
6. Centers for Medicare and Medicaid Services. RAI

Version 3.0 Manual. Available online atwww.cms.gov/NursingHomeQualityInits/Downloads/MDS30RAIManual20100127.zip.
7. CDC. "ICD-9-CM Official Guidelines for Coding and Reporting."
8. Ibid.
9. Ibid.
10. AHA. *Coding Clinic for ICD-9-CM* 15, no. 4 (Fourth Quarter 1999): 4.
11. CDC. "ICD-9-CM Official Guidelines for Coding and Reporting."
12. Ibid.
13. Department of Health and Human Services, Office of Inspector General. "Office of Inspector General's Compliance Program Guidance for Nursing Facilities." Section II.B.2.c. *Federal Register* 65, no. 52 (March 16, 2000). Available online at http://oig.hhs.gov/authorities/docs/cpgnf.pdf.

Resources

AHA Central Office. *Coding Clinic* and Other Products. Available online atwww.ahacentraloffice.com/ahacentraloffice/html/products.html.

AHIMA. "ICD-10-CM/PCS." Available online at www.ahima.org/icd10/default.aspx.

Centers for Medicare and Medicaid Services (CMS). "Transactions and Code Sets Regulations." Available online atwww.cms.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp.

CMS. Medicare Claims Processing Manual. Available online at www.cms.gov/Manuals/IOM/itemdetailasp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912 .

CMS. Medicare Program Integrity Manual. Available online at www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019033

Appendixes

Three additional appendixes are included in the online version of this brief, available in the AHIMA Body of Knowledge atwww.ahima.org:

- Appendix A: Planning for the ICD-10-CM Transition for LTC Facilities
- Appendix B: Reporting and Sequencing Diagnoses on the Health Record and UB-04 Claim Form
- Appendix C: Regulatory Guidance for Reporting Diagnoses Related to Reimbursement

Prepared By

Nancy Benson, RHIA
June Bronnert, RHIA, CCS, CCS-P

Amy Eckert, RHIT
Susan Elliott, RHIA
Debbie Johnson, RHIT, CHP
Charlotte Lefert, RHIA, RAC-CT
Mindy Maupin, RHIT
Mary Ann Michau, MS, RHIA
Monica Baggio Tormey, RHIA, CHP
Carol Young, RHIT

Reviewed By

Judy Bielby, MBA, RHIA, CPHQ, CCS
Sue Bowman, RHIA, CCS
Linda Hyde, RHIA
Mary Ann Leonard, RHIA, CRM, RAC-CT
Junius Logan, MD
Mary Meysenburg, MPA, RHIA, CCS
Diana Warner, MS, RHIA, CHPS
Margie White, MS, RHIA, NHA
Terminology and Classification Practice Council

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